

VDH-OMHHE-MARY MARSHALL NURSING SCHOLARSHIP PROGRAM

2015 APPLICATION-LICENSED PRACTICAL NURSES

APPLICATION CHECKLIST AND REQUIREMENTS

This checklist must be reviewed thoroughly and submitted as part of a completed application. Incomplete applications will not be considered for award and failure to comply with any of these application requirements will result in the applicant being ineligible for award.

Mary Marshall Nursing scholarships are for students enrolled in undergraduate nursing programs. Undergraduate nursing programs are defined as those leading to a diploma, an associate degree, or baccalaureate degree in nursing. Under the law, all scholarship awards are made by an Advisory Committee appointed by the State Board of Health. The Office of Minority Health and Health Equity (OMHHE) of the State Health Department serves as the staff element to the Advisory Committee and has no role in the determination of scholarship recipients. The basis for determining scholarship recipients is established by the Advisory Committee with due regard given to scholastic attainment, financial need, character, and adaptability to the nursing profession.

- ☐ Applicant must be a United States Citizen, National, hold an immigration visa or classified as a political refugee as verified by a social security number included in the application. **Persons with a temporary or student visa are not eligible.**
- ☐ Applicant must be a resident of the State of Virginia for at least one year. Verification provided must prove that the applicant has lived in VA for at least one year (ex. Renewal date on driver's license, previous year on voter registration card, motor vehicle registration/employment records/deed of property/ sources of financial support, etc if they reflect multiple years). Please provide one of the following appropriate forms of verification: 1.) State Income Tax record or statement 2.) Driver's license with renewal information 3.) Voter registration card 4.) Motor vehicle registration 5.) Employment record 6.) Ownership of real property 7.) Financial support records.
- ☐ Applicant must attach a one page Narrative Summary. **"Section 7-Narrative Summary" must be printed at the top of the page. The applicant should sign and date the bottom of the page. (The Narrative Summary will not be accepted if not submitted as stated above.) In one page or less, the summary must briefly explain the significance of the Mary Marshall Nursing Scholarship in pursuing his/her educational goals, any school/community activities, and any skill-set that is pertinent to the nursing profession. It is important that the applicant consider including plans for professional practice in Virginia following graduation. If the Narrative Summary exceeds the one page limit, it will not be accepted.**
- ☐ Applicant must be accepted to or enrolled in a school of nursing in the State of Virginia which is approved by the State Board of Nursing. The applicant must have the Dean/Director/Chair of the Applicant's School of Nursing complete **Section 8** of the application, provide an **original signature** and have it returned to him/her to be submitted with the application. **Section 8 will not be accepted if it is not submitted with the application**
- ☐ Applicant **must attach an official transcript** of grades from all schools attended. **The transcript will not be accepted if it is not submitted with the application.** The applicant must demonstrate a cumulative grade point average (GPA) of at least 2.5 if currently enrolled in and attending a nursing program.
- ☐ Applicant must demonstrate financial need verified by a Financial Aid Officer/authorized person. The applicant must file one or more of the following: 1) Financial Aid Form (FAF) of the College Scholarship Service 2) the Family Financial Statement (FFS) of the American College Testing or 3) the Free Application for Federal Student Aid (FAFSA) with the institution they are attending or will attend for determination of financial need. The recommendation of the Financial Aid Officer must be based upon one of the three above referenced need analysis documents and must include a specific dollar amount determined to be the applicant's financial need. The Financial Aid Officer/Authorized Person must provide **original signatures** in **Section 9** of the application.
- ☐ **Applications must be typed and have all appropriate documents attached.** Applicants are advised to keep a copy for their records. Application open period is **May 1 to June 30** for the fall academic year. Applications are not accepted prior to May 1st, and must be **postmarked by June 30th**. Please mail completed applications to:

*Virginia Department of Health
Office of Minority Health and Health Equity
ATTN: Workforce Incentive Programs
109 Governor St., Suite 1016-East Richmond, Virginia 23219*

If you have any questions, please contact The Office of Minority Health and Health Equity at 804-864-7435.

SECTION 1 – PERSONAL DATA

Date of Application: _____

Legal Name:

_____	_____	_____	_____
Last	First	MI	Maiden

Preferred Name: _____

Address:

Street Address

_____	_____	_____
City	State	Zip

Day Phone Number: _____

Evening Phone Number: _____

Email Address: _____

Social Security Number: _____

Sex: Please Select One

Date of Birth
and Age: _____

Place of Birth: _____

Race/Ethnicity: Please Select One Other: _____

How long have you been a resident of Virginia? _____

Do you have an active military service obligation? Please Select One

Congressional District: _____
(Please check with your voter registration office or visit
<http://nationalatlas.gov/printable/congress.html>)

Are you a high school graduate? Please Select One Do you possess a GED? Please Select One

Are you a certified Nursing Aide (CNA)? Please Select One

Have you ever received a Mary Marshall Nursing Scholarship? Please Select One

If yes, in what year(s)? _____

If you had a different name when you applied previously, please provide it here: _____

What school of nursing were you attending during that time? _____

Do you speak another language? Please Select One If yes, please list: _____

ALTERNATE CONTACT PERSON (OTHER THAN APPLICANT)

Name: _____
Last First MI

Address: _____
Street Address

_____ City State Zip

Phone Number: _____ Relationship to Applicant: _____

SECTION 2 – NURSING EDUCATION

School of Nursing: _____

Student Identification or
Social Security Number: _____

Address: _____
Street Address

_____ City State Zip

Phone Number : _____

☐ Full-time Student: ☐ Part-time Student: If part-time, how many credit hours are you taking? _____

Have you transferred to this school from another nursing program? Please Select One

Name of previous school: _____

Date of enrollment in present Nursing Program: _____
Month Day Year

Expected date of graduation: _____
Month Day Year

Nursing Program Level: Please check the program type and current level. Specify level in September.

<u>Program</u>	<u>Current Level</u>	<u>Level in September</u>
<u>Please Select One</u>	<u>Please Select One</u>	<u>Please Select One</u>

SECTION 3 – PRIOR EDUCATION

Please check the program types that you have successfully obtained.

☐ CNA ☐ LPN ☐ AAS, RN ☐ BSN ☐ other _____

Current License: _____ Current License Number: _____

	School	Diploma/Degree	City and State	Dates of Attendance	Reason for Leaving
1.				to	
2.				to	
3.				to	

SECTION 4 – WORK EXPERIENCE

☐ Check here if you have never been employed, and skip to Section 5

	Position	Name of Employer	City and State	Dates of Employment	Reason for Leaving
1.				to	
2.				to	
3.				to	

SECTION 5 – OTHER HEALTH-RELATED AND/OR CIVIC EXPERIENCES

☐ Check here if you have never been involved in any health related and/or Civic Activities, and skip to Section 6

	Position	Organization	City and State	Dates of activities
1.				to
2.				to
3.				to

SECTION 6 – OTHER FINANCIAL ASSISTANCE

Are you receiving any other type of financial aid for the upcoming school year? Please Select One

Please indicate:

SECTION 7 – NARRATIVE SUMMARY (Must submit as an attachment on a separate sheet)

Briefly explain, *in one page or less*, the significance of the Mary Marshall Nursing Scholarship in pursuing your educational goals. Also, include school and/or community activities as well as any skill-set that is pertinent to your profession. It is important that you consider including plans for professional practice in Virginia following graduation. Applicant **must** label the top of the attached sheet **“Section 7-Narrative Summary”**, print name, provide an original signature, and the current date. **If the Narrative Summary exceeds the one page limit, it will not be accepted.**

SECTION 8 – SCHOOL OF NURSING RECOMMENDATION

To be completed by the Dean/Director of the School of Nursing

1. Name of applicant: _____
2. Student Identification or Social Security Number: _____
3. This applicant is: Please Select One
4. Date of entrance: Month _____ Year _____
5. During this award period, the applicant will be a: Please Select One
6. *If student is currently enrolled in your Nursing Program, please provide a cumulative grade point average of current nursing courses. Applicants must have at least a 2.5 cumulative GPA in Required Nursing Courses, electives should not be considered in GPA: List GPA _____*

Source of computing GPA: Please Select One If other, please specify: _____
7. Please provide a brief recommendation (in 1,600 characters or less) based on the student's scholastic attainment, character, need, adaptability, and/ or other attributes.

Please provide an original signature from authorized personnel.

I recommend _____ for a Mary Marshall Nursing Scholarship Award.
Full Name of Applicant

Name of Authorized Personnel Completing This Section

Title

Signature

Date

Full Name of School of Nursing

Phone Number E-mail Address

SECTION 9 – FINANCIAL NEED RECOMMENDATION

To be completed and signed by the Financial Aid Officer or Program Director

This section must include a monetary recommendation. The Mary Marshall Nursing Scholarship is a need-based aid program; therefore, the amount recommended must be documented by one of the accepted uniform methodology needs analysis systems. Please use the most recent needs analysis on file for this student to recommend the amount of scholarship required to meet need, after taking into consideration other financial aid already received by the applicant.

1. Applicant Name: _____
2. Student Identification or Social Security Number _____
3. **Student Costs and Resources:**
Student Aid Budget for Applicant _____
Expected Family Contribution (EFC) _____
Financial Aid Received (excluding loans) _____
Remaining Need _____
Cost of Program for One Year _____
(including tuition, fees, books, uniforms, etc.) _____

4. **Scholarship Recommendation:**
Award range for undergraduates must be at least \$150.00 and must not exceed \$2,000 annually. The Mary Marshall Nursing Scholarship Committee will not make an award that exceeds the financial aid officer's recommendation, listed above.

After reviewing the applicant's financial situation, I recommend a
Mary Marshall Nursing Scholarship award of (*check one*):

- ☐ \$150 to \$600 Annually
☐ \$601 to \$1,200 Annually
☐ \$1,201 to \$2000 Annually

If your recommendation is less than both the "remaining need" above and the maximum allowable reflected in the award range above, please explain:

5. Needs Analysis Method Used:

Please indicate which of the following methods was used in determining the applicant's financial need and the academic year for which the form was filed. (Financial Aid Officers are encouraged to use the need analysis for the year in which the student is applying for assistance.)

<input type="checkbox"/> CSS	<input type="checkbox"/> ACT	<input type="checkbox"/> PELL	<input type="checkbox"/> FAFSA	Academic Year: 2015 to 2016
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6. **Please specify any extenuating circumstances which may have influenced your recommendation.**

Please provide an original signature from authorized personnel.

Name of Financial Aid Officer/Authorized Personnel (Please Print)

Phone Number

Signature of Financial Aid Officer/Authorized Personnel

Date

E-Mail Address:

SECTION 10 – CERTIFICATION STATEMENT

I, the undersigned, hereby certify that all of the information on this scholarship application is true and complete to the best of my knowledge. I realize that information from this application will be used to determine scholarship eligibility. If asked by the Nursing Scholarship Advisory Committee, I agree to provide documentation verifying any information on this application. I have read and accept the conditions of the Mary Marshall Nursing Scholarship.

Signature of Applicant

Date

Full Name (Please Print)

Any persons dissatisfied with the award or denial of an application to become a scholarship participant must notify staff of the Nursing Scholarship Advisory Committee within 14 days of receiving notification of the award or denial of an application.

For marketing purposes, how did you learn about this scholarship opportunity? _____

Thank you for your interest in this program!

Staff Record Only: ☐ *Application complete upon receipt* ☐ *Additional information requested*